Department of Insurance
State of Arizona
Office of the Director
Telephone: (602) 912-8456
Facsimile: (602) 912-8452

JANET NAPOLITANO
Governor

2910 North 44th Street, 2nd Floor
Phoenix, Arizona 85018-7256
www.id.state.az.us

CHRISTINA URIAS
Director of Insurance

REGULATORY BULLETIN 2004-02*

To: Insurance Producers, Surplus Lines Brokers, Insurance Industry Representatives, Insurance Trade Associations, Life & Disability Insurers, Property & Casualty Insurers, And Other Interested Parties

From: Christina Urias
Director of Insurance

Date: July 26, 2004

Re: **2004 Arizona Insurance Laws**

This Regulatory Bulletin summarizes the major pieces of newly enacted legislation affecting the Department, its licensees, and insurance consumers. This summary is not meant as an exhaustive list or a detailed legal analysis of all insurance related bills. It generally describes the substantive content, but does not capture all details or necessarily cover all bills that may be of interest to a particular reader. The Department may follow this bulletin with other, more detailed bulletins related to implementation of specific bills. Please do not regard this summary as a legal opinion or a binding interpretation of the legislation. All interested persons are encouraged to obtain copies of the enacted bills by contacting the Arizona Secretary of State's Office at (602) 542-4086 or from the Arizona legislative web site at the following internet address: http://www.azleg.state.az.us. Please direct any questions regarding this bulletin to Jennifer Boucek, Executive Assistant for Policy Affairs, 602/912-8456.

The 2004 Arizona Forty-sixth Legislature, Second Regular Session, adjourned *sine die* on May 26, 2004. Except as otherwise noted below, all insurance related legislation has a general effective date of August 25, 2004.

* This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties you may petition the agency under Arizona Revised Statutes Section 41-1033 for a review of the Statement.

The Department initiated HB2228, which is described first.

DEPARTMENT BILL

HB2228. Charitable gift annuities (Ch. 30)

HB 2228 imposes new requirements on entities that offer charitable gift annuities to donors. A charitable gift annuity is a contract between the donor and a charity in which the donor transfers assets to the charity in exchange for the charity's promise to pay a fixed annual amount to the donor for a defined period (usually life). The charity receives the surplus of the donated assets, which exceed the present value of the expected payments to the donor. The donor, in turn, receives a charitable tax deduction equal to the difference between the present value of the expected payments and the value of the donated assets.

Amends A.R.S. § 20-119:

- Adds the following new requirements for charitable organizations offering charitable gift annuities:
  1. A minimum of $300,000 unrestricted cash or securities, exclusive of assets, funding the charitable gift agreement.
  2. A history of continuous operation for at least three years.
  3. An annual audit of its operations conducted by an independent certified public accountant for the past two fiscal years.
- Requires any person offering a charitable gift annuity to provide the following information in writing to a donor prior to entering into an agreement:
  1. The name, address and description of the charitable organization offering the charitable gift annuity.
  2. A statement that a charitable organization will make additional financial information available to the donor.
  3. A disclosure that the charitable gift annuity is not insurance, is not subject to regulation by the Director of DOI and is not protected by any state guaranty fund.
  4. A disclosure that this State and DOI have not approved or disapproved the charitable gift annuity being offered and have not determined whether any information given to the donor is truthful.
- Permits a donor two years in which to bring an action against a charitable organization for violation of A.R.S. § 20-119. If the donor is successful in proving violations of this statute, the donor can recover the amount of the consideration paid for the charitable gift annuity, with interest, taxable court costs and reasonable attorney fees minus the amount of income received from the charitable gift annuity.
- Prohibits a person from directly or indirectly paying or accepting a commission in connection with the solicitation or negotiation of a charitable gift annuity. This prohibition does not, however, prevent a charitable organization from paying regular compensation to its employees for authorized charitable purposes.

OTHER INSURANCE-RELATED BILLS

HB2232. Insurance producer licenses; renewal (Ch. 162)
(**Delayed effective date of January 1, 2005 for amendments to A.R.S. §§ 20-167, 20-289, 20-2580, 20-2901 and 20-2902**.)
Extends the term for licenses of insurance professionals, changes the date on which professional licenses expire, adjusts licensing fees and modifies continuing education (CE) requirements.

Amends A.R.S. § 20-167:

- Provides that the DOI issue licenses, including surplus lines broker's licenses, quadrennially at double the fee for the biennial license.
- Replaces biennial license fee ranges with quadrennial license fee ranges.
- Clarifies that fees collected from captive insurers are not deposited in the General Fund.

Amends A.R.S. § 20-286:

- Authorizes the DOI Director to issue licenses electronically.
- Clarifies the DOI Director's authority to require the submittal of a set of fingerprints for each new member, director, officer or designated producer of a business entity licensee for the purpose of a background check. Permits the Department of Public Safety to share this fingerprint data with the FBI
- Requires a licensee to inform the Director of DOI in writing within 30 days of any change in the licensee's name.

Amends A.R.S. § 20-289:

- Extends the term of an insurance producer's license from two years to four years.
- Adjusts licensing fees to twice the amount of the two-year license fee, effective January 1, 2005.
- Provides that an individual's license expires on the last day of the month of the licensee's birthday, not less than three years and not more than four years after the last day of the month in which a license is issued.
- Provides that a business entity's license expires on the last day of the month, four years after the license was issued or renewed.
- Extends, from six months to one year, the period in which a qualified applicant may renew an expired license.
- Extends, from six months to one year, the period in which a person who surrenders an authority or a license may not reapply for the same authority or license.

Amends A.R.S. § 20-293 to provide that authority to solicit applications and issue policies by means of mechanical vending machines expires on the same date as the controlling insurance producer's license.

Amends A.R.S. § 20-1561 to make certain sections of the insurance code expressly applicable to title insurance agents.

Repeals A.R.S. § 20-1579, which required title insurers to certify to the Director the names of all title insurers representing them in Arizona.

Amends A.R.S. § 20-1580 to extend the term of a title insurance agent's license from two years to four years.

Amends A.R.S. § 20-2901, the definitions section of the CE chapter of the insurance code:

- Adds a definition for "license period".
- Deletes the definition for "line of insurance".
- Expands the definition of "licensee" to include an insurance producer who *at any time during the license period* holds a nonresident license to transact insurance in another state.

Amends A.R.S. § 20-2902 governing CE requirements for insurance producers:

- Requires all Arizona residents licensed in Arizona for one year or more, who, at any time during the license period, holds a nonresident license to complete a minimum of 40 hours of insurance CE courses. Previously, an Arizona resident would only have to complete CE if they held a nonresident license on the date the Department received a license renewal application.
- Gives the Director discretion as to whether a signed certificate of compliance must be submitted with the license renewal application. The statute formerly required a licensee to attach the certificate of compliance.
- Eliminates the requirement that the CE certificate of compliance include the licensee's address and social security number, effective January 1, 2005.

Amends A.R.S. § 20-2904 to eliminate the contract CE administrator's obligation to biennially review of the required number of courses and the CE.

Amends A.R.S. § 20-2905 to eliminate the requirements that (a) the Continuing Education Review Committee (CERC) hold a meeting semiannually; and, (b) one CERC meeting be held outside of Maricopa County each year.

Requires the DOI Director to prescribe a quadrennial license fee effective January 1, 2005, at twice the fee that was effective for a biennial license on December 31, 2004.

Requires the DOI Director to revise quadrennial license fees using the current statutory method for all other fee categories.

Requires a licensee whose license number is an odd number and expires in 2005 or 2006 to renew the license by paying one-half the quadrennial license fee and completing one-half of the CE requirements. (NOTE – This requirement was further amended by HB 2270).

Provides that the Director shall renew the license of a licensee whose license number is an odd number and expires in 2005 or 2006 for a period of two years.

Makes technical and conforming changes.

HB 2270. Rental car insurance; damage waiver (Ch. 317)

Stipulates that collision damage waivers are not insurance and clarifies continuing education (CE) requirements for renewal of insurance producers' licenses.

Amends A.R.S. § 20-103 to codify that collision damage waivers are not insurance.

Amends A.R.S. § 20-331 to clarify that rental car agents are not subject to the CE requirements for insurance producers under Title 20.

Amends A.R.S. § 20-2901, as amended by Laws 2004, Chapter 162, section 9 (see HB2232, above):

- Clarifies that the definition for "license period" refers to the license period of an Arizona insurance license.
- Deletes "a person who holds a nonresident license from this state" from the list of persons excluded from the definition of licensee because the text is duplicative of text elsewhere in the Article.

Amends A.R.S. § 20-2902:

- Decreases the number of insurance CE hours from 40 to 20 for insurance producers who are seeking to renew a resident license and whose expiring license period is from one to two years.
- Clarifies that licensee whose expiring license period is more than two years must complete a minimum of forty hours of CE requirements.

Amends Laws 2004, Chapter 162, Section 14 (see HB2232, above) to delete the requirement that a person seeking renewal of an insurance producer's license whose license expires during the period from January 1, 2005 through December 31, 2006, and whose license number is an odd number submit evidence of completing one-half of the number of CE hours.

Makes technical changes.

HB2224. Insurer claim files: access by director; definitions (Ch. 162)

HB2224 prohibits the Director of the Department of Insurance from disclosing confidential information obtained from an insurer's claim files, except in specified instances.

Enacts A.R.S. §20-157.01:

- Reaffirms the Director's authority to request claims files and insurers' duty to comply with such requests.
- States that all documents, reports or other materials provided to the Director pursuant to A.R.S. § 20-157.01 are confidential, and are not subject to disclosure, including discovery or subpoena, unless the subpoena is issued by the Attorney General, County Attorney or by a court at the request of the Attorney General, County Attorney or other law enforcement agency.

- Stipulates that the Director may disclose the information to a law enforcement agency only if the agency:
  1. Submits a lawful request, subpoena or formal discovery procedure.
  2. Can warrant confidentiality of the documents pursuant to A.R.S. §20-158(F).
- Requires the Director to make reasonable efforts to notify an insurer of any request for documents made confidential by the statute so that the insurer may assert any applicable privileges in court.
- Stipulates that the Director may use the documents, reports or other materials in furtherance of the Department's regulatory responsibilities.
- Defines "insurer claim file" to include medical records, repair estimates, adjuster notes, insurance policy provisions, recordings or transcripts of witness interviews and any other records of coverage, settlement, payment or denial of a claim.

HB2233. Consumer reporting agency; information disclosure (Ch.31)

HB2233 enacts section A.R.S. § 20-2113.01, which prohibits consumer-reporting agencies from providing or selling any personal or privileged information obtained during an insurance transaction.

Enacts A.R.S. §20-2113.01:

- Prohibits a consumer-reporting agency from providing or selling data or lists that include any information about an individual collected or received in connection with an insurance inquiry about the insured's credit history or insurance score.
- Does not apply to lists or data provided to the insurance producer from whom the information was obtained, the insurance company on whose behalf the producer acts or the insurer's affiliates or holding companies that are acting on behalf of the insurer.
- Does not restrict an insurer from obtaining a claims history report or a motor vehicle report.

HB2235. Captive insurers; formation (Ch. 32)

HB2235 amends the captive insurance act to allow non-profit corporations to form group and pure captive insurers and permit "industry groups" to use a third party consultant to procure the insurance of any risk.

Amends A.R.S.§20-1098:

- Expands the definition of "industry group" to allow the use of third party consultants, in addition to employees, as the industry group's insurance manager.

Amends A.R.S. §20-1098.04:

- Permits a group captive and pure captive insurer to be incorporated as a nonprofit corporation pursuant to Title 10, Chapter 25.

HB2239. Annuities; standard nonforfeiture law (Ch.119)

HB2239 replaces the current one and one-half percent minimum non-forfeiture interest rate for individual deferred annuity contracts with an indexed interest rate and makes other modifications to the annuity contracts to conform.

.
In 2003, the National Association of Insurance Commissioners (NAIC) adopted a model law which establishes a minimum non-forfeiture rate for annuities based upon the five-year Constant Maturity Treasury Rate (CMT rate) that is reduced by 125 basis points, or 1.25 percent. The five-year CMT rate in an index published by the Federal Reserve Board based on the average yield of a range of U.S. Treasury securities, all adjusted to the equivalent of a five-year maturity. Additionally, the model law states that the guaranteed minimum interest rate cannot exceed three percent and may not fall below one percent. HB2239 conforms Arizona law to the NAIC model.

Amends A.R.S. § 20-1232:

- Changes the minimum non-forfeiture interest rate for individual deferred annuity contracts from one and one-half percent to the lesser of three percent and the five-year CMT rate reduced by 125 basis points, but not less than one percent.
- Specifies the five-year CMT rate may be the rate reported by the Federal Reserve as of a date or an average over a period of time rounded to the nearest one-twentieth of one percent. The date must be specified in the contract no longer than fifteen months before the contract issue or redetermination date.
- Requires the interest rate to apply for an initial period; allows the interest rate to be redetermined for additional periods so long as the redetermination date, basis and period, if any are stated in the contract.
- Specifies the basis is the date or average over a specified period that produces the value of the five-year CMT rate to be used at each redetermination date.
- Allows a contract that provides substantive participation in an equity-indexed benefit to increase the reduction of the interest rate by an additional 100 basis points to reflect the value of the equity index benefit. However, the present value of the additional 100 basis point reduction cannot exceed the market value of the benefit at the contract issue date, and at each redetermination date. The DOI Director may require a demonstration that it has not exceeded the market value of the benefit. The Director may disallow or limit the additional reduction if it exceeds the market value of the benefit.
- Authorizes the Director to adopt rules regarding the changes made to individual deferred annuities, including the minimum non-forfeiture interest rate, the use of an equity indexed benefit, and further adjustments, determined by the Director as necessary.
- Increases, from $30 to $50, the annual contract fee for an individual deferred annuity.
- Amends the “net considerations” used to determine the minimum nonforfeiture amount from sixty-five percent to eighty-seven percent, thereby reducing, from 35 percent to 12.5 percent, the first year expense amount an insurance company can deduct from premiums for its expenses.
- Requires that, upon written request of the contract owner, an insurance company must provide a paid-up annuity benefit of such value as specified in A.R.S. § 20-1232.
- Permits, instead of requires, an insurance company to reserve the right to defer the payment of the cash surrender benefit for a period not to exceed 6 months after demand for such cash surrender benefit.
- Requires the insurance company to request in writing and receive written approval from the Director before reserving the right to defer a cash surrender payment.
- Makes technical and conforming changes.

After August 26, 2004 and before August 26, 2006, an insurer may elect to apply the changes made to individual deferred annuities to an annuity contract. As of August 26, 2006, the

changes made to individual deferred annuities apply to all annuity contracts that are issued by an insurer.

HB2313. Insurance policies; annuity contracts; replacement (Ch. 244)
Modifies statutes regulating the replacement of life insurance and annuity contracts to conform Arizona statutes to the NAIC model legislation regarding annuity contracts.

Amends A.R.S. § 20-1241:

- Supplements the definition of "financed purchase." For purposes of regulatory review, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same insurer within four months before, or thirteen months after, the effective date of the new policy, it is deemed evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This definition does not increase or decrease the monitoring obligations of insurance producers under A.R.S. § 20-1241.04(B)(5)

Amends A.R.S. § 20-1241.01:

- Clarifies that Chapter 6, Article 1.1. of Title 20 does not apply to the replacement of policies and contracts used to fund an employee pension and welfare plan as defined by and subject to the employee retirement and income security act of 1974 (ERISA), unless the policies and contracts meet all of the requirements of A.R.S. §2 0-1241.01(C).

Amends A.R.S. § 20-1241.03 to require an insurance producer, in any replacement transaction in which an application for a new policy or contract is completed, to give the applicant the original or a copy of all sales material at the time of the application for the new policy or contract.

HB2324. Life insurance and annuities; benefits; exemption from seizure; exceptions (Ch.201)
HB2324 exempts life, health or accident insurance policies and employer or individual annuity contracts from debt liability.

Amends A.R.S. § 20-1131 to strike the phrase "or in any proceeding" from the statute, which exempts up to $25,000 of the cash surrender value of a life insurance policy from the claims of creditors in the event of bankruptcy before any court in this state. Previously, the statute exempted up to $25,000 of the cash surrender value in both bankruptcy proceedings "or in any proceedings" before any court in this state. This exemption applies only if the life insurance policy is held for at least two years and the beneficiary is the spouse, child, parent, sibling or other dependent of the policy owner.

Enacts A.R.S. § 20-1131.01:

- Fully exempts life, health or accident insurance policies and employer or individual annuity or benefit plans from garnishment, attachment, execution, seizure or any legal process of law to pay a debt or other liability of an insured or beneficiary, either before or after the benefits are provided.

- Specifies that insurance and annuity benefits inure exclusively to the benefit of the designated beneficiary.
- Applies the exemption to any benefits, including cash value and proceeds, of a life, health or accident insurance policy or annuity or benefit plan used by an employer or individual.
- Specifies that the exemption applies regardless of whether the power to change the beneficiary is reserved to the insured, or the insured or the insured's estate is a contingent beneficiary.
- Specifies that the exemption does not apply to premium payments made in fraud of creditors or a debt that is secured by a pledge of the cash value of a an insurance policy or the proceeds of the policy.

.

HB2370. Association Groups (Ch.164)

HB2370 allows association groups to provide group life insurance.

Enacts A.RS. § 20-1251:

- Permits the sale of life insurance policies to associations, trusts or the trustees of a fund established by or maintained for the benefit of an association, to providing life insurance to the association's employees, members and employees of the association's members.
- Requires that the association, trust or trustee be deemed the policyholder of the life insurance policy.
- Specifies that the policy be for the benefit of persons other than the association or any of its officials, representatives or agents.
- Requires an association to have a constitution and bylaws and be organized and managed in good faith for a purpose other than obtaining insurance.
- Requires the policy to cover at least two persons at the date of issue.
- Stipulates that the policy may provide that the term "employees" include retired employees.

HB2463. Towed vehicles; release; insurance companies (Ch. 144)

HB2463 requires the written consent of the vehicle owner prior to the insurance company's removal of the vehicle from the towing storage facility, unless the insurance company includes a statement in the Vehicle Release Request that:

- The insurer has the vehicle owner's permission to remove the vehicle from the tower's storage facility.
- The vehicle owner has been informed that the tower is not liable for undisclosed loss or damage to the vehicle before the vehicle's removal from the tower's facility.

Amends A.R.S. § 28-4847:

- Requires that a towing company release a vehicle on the day the towing company receives both the Vehicle Release Request and payment.
- Requires the Vehicle Release Request to include:
  1. The insurer's name, address and telephone number.
  2. The owner's address, telephone number and the name of the insured, if different from the owner.
  3. The owner's written consent to release the vehicle.
  4. The owner's signature, or a statement that the insurer has authorization from the vehicle owner to remove the vehicle from the towing company's storage premises.

5. A statement that the vehicle owner has been informed that the towing company is presumptively not liable for undisclosed loss of personal property or damage to the vehicle before the vehicle's removal from the towing company's facility.
6. A statement that the owner may inspect the vehicle at the towing company's storage premises, remove any personal property from the vehicle and report any vehicle damage to the towing company the time of inspection.

- Creates a rebuttable presumption that damage to the vehicle or loss of personal property did not occur while the vehicle was in the custody of the towing company if the vehicle owner:
  1. Does not inspect the vehicle prior to its removal from the towing facility.
  2. Has inspected the vehicle and has had an opportunity to remove personal property from the vehicle.
- The presumption may be overcome by a preponderance of evidence to the contrary.
- Permits proration of partial storage days based on the towing company's contract with a political subdivision.
- Prohibits a towing company from charging additional storage fees, except for proration for partial storage days, if:
  1. The towing company receives the written Vehicle Release Request.
  2. The insurance company removes the vehicle from the tower's storage premises during normal business hours on the same day that the towing company receives the Vehicle Release Request.
- The statute does not create a cause of action against a towing company that releases a vehicle to a person other than the vehicle owner if the owner or an insurance company provides written authorization for the release.
- Defines vehicle owner.

HB2468. Auto insurance; repair facility (Ch. 233)

HB2468 specifies that an insured or claimant has a right to choose any repair facility for the repair of motor vehicle damage, subject to the policy's notice of loss or claim provisions. In addition, HB 2468 prohibits an insurance adjuster from having any authority over vehicle repair decisions or recommendations in a repair facility owned by an insurer. It also provides that an insurer that, as a general business practice, violates these provisions shall be liable for civil penalties. Finally, HB 2468 contains a reporting requirement on insurer-owned repair facilities relating to the number of vehicle repaired and dollar amounts of the repairs.

Enacts A.R.S. § 20-468

- Provides that a person has the right to choose any repair facility for the repair of a motor vehicle loss.
- Expressly exempts glass repair facilities from the class of repair facilities covered by the statute.
- Provides that a person's right to choose a repair facility is subject to an insurer's right to receive notice of loss or claim as maybe consistent with its policy terms.
- Requires an insurer who provides repair facility information also simultaneously advise about a person's right to choose any repair facility.
- Stipulates that the statute does not create a private right or cause of action.
- Provides that when the insured or claimant chooses an insurer owned (in whole or in part) repair facility, the adjuster handling the claim cannot be employed by the repair facility or have any direct authority over that facility's recommendations relating to the repair of the vehicle.

- Through January 10, 2008, requires insurers (owning an interest in vehicle repair facilities that are in the business of repairing or replacing non-mechanical parts for damaged motor vehicles) file annually with the DOI Director:
  1. A statement of: (a) the number of motor vehicles repaired; and, (b) the dollar values of the repairs by each repair facility for the previous calendar year for which the vehicle owners were either insured by, or were claimants of the insurer; and, (c) the total number of motor vehicles repaired and the dollar values by each repair facility for insureds or claimants, as a percentage of the total number of vehicles repaired, or total dollar values of repairs made by each repair facility for that calendar year.
- Annual reports filed with the Department of Insurance are confidential, but shall be made available to the President of the Senate or the Speaker of the House of Representatives upon request.

.

HB2547. Insurance inquiries; use by insurer (Ch. 149)
(A.R.S. § 20-1652(E) amended retroactively to January 1, 2004; other amendments have a general effective date.)
HB2547 prohibits an insurance company from considering an insured's mere inquiry about policy terms and coverage as a claim. The law also precludes an insurer from terminating a binder of insurance after 30 days from the date of application based on consumer report information.

Amends A.R.S. § 20-1652:

- Amends paragraph (E) to clarify that after thirty days from the application by an insured for insurance coverage an insurer cannot terminate a binder based upon information from a consumer report.
- The clarifying amendment to paragraph (E) applies retroactively to January 1, 2004.
- Enacts Paragraph (F) to prohibit an insurer from considering an insured's mere inquiry as to policy terms or coverage as a claim. Further prohibits an insurer from using such inquiry, (regardless of the source of the information) as a basis for declining, non-renewing, or canceling coverage, or terminating a binder of insurance.
- Prohibits an insurer from reporting insureds' inquiries regarding policy terms or coverage, to any insurance support organization or consumer-reporting agency.
- Mere inquiry into coverage on a property insurance policy is not claim activity unless an insured actually files a claim that results in an insurer claim investigation.
- Enacts subsection (G) to clarify that the terms "consumer reporting agency" and "insurance support organization" as used in A.R.S. §20-1652 have the same meaning prescribed in A.R.S. §20-2012.

HB2551. Insurance; utilization review agent; qualification (Ch.211)
Employment of a person convicted of a misdemeanor involving moral turpitude is no longer grounds to deny a utilization review agent certificate.

Amends A.R.S. § 20-2508:

- The Director of the Department of Insurance (DOI) is no longer required to deny a certificate to a utilization review agent who employs a person convicted of a misdemeanor involving moral turpitude.

- Makes a technical change.

HB2684. Vehicle protection product warranties (Ch. 2684)

Establishes regulations for vehicle protection products, which are devices or services installed in a vehicle to deter theft loss or damage and assist in stolen vehicle recoveries. The product warranty is designed to protect the consumer from theft losses due to product failure when the loss exceeds the vehicle's insurance coverage.

Adds Article 15, "Vehicle Protection Products" to Chapter 4 of Title 20.

Enacts A.R.S. § 20-1099:

- Provides definitions for "administrator"; "incidental costs"; "vehicle protection product"; "vehicle protection product warrantor"; and, "warranty reimbursement insurance policy"

Enacts A.R.S. § 20-1099.01:

- Provides that a vehicle protection product that meets the requirements of the § 20-1099.02 are express warranties and not insurance, and thus are not subject to Title 20. Further, any person who sells or administers vehicle protection product warranties is not required to comply with Title 20.

Enacts A.R.S. § 20-1099.02:

- Exempts a vehicle protection product from the regulations of the insurance code if the product:
  1. Identifies the warrantor, the seller, the warranty holder and the terms of the sale.
  2. States conspicuously that a warranty reimbursement policy guarantees the warrantor obligations to the warranty holder.
  3. States conspicuously that, if the warrantor does not provide the payment due under the terms of the warranty (within 60 days after filing or proof of loss) the warranty holder may file a claim directly under the warranty reimbursement insurance policy.
- Requires a warranty reimbursement insurance policy to have the following provisions:
  1. The warranty reimbursement insurance company will reimburse all covered sums that the warrantor is legally obligated to pay, or will provide the service that the warrantor is legally obligated to perform, under the vehicle protection product warranty.
  2. The warranty holder may file directly with the warranty reimbursement insurance policy if after filing the warrantor does not provide the payment due under the terms of the warranty within 60 days after proof of loss.
- Defines terms.
- Stipulates that the provisions apply only to vehicle protection products sold, or offered for sale, on or after the statute's general effective date.

SB1094. Unfair claims; medical necessity review (Ch. 5)

(Delayed effective date of January 1, 2005)

Allows an insurer to apply Medical Necessity Review to a particular type of service or treatment without violating the Unfair Claims Settlement Practices Act.

Amends A.R.S. § 20-461(B):

- Prohibits a determination that an insurer is discriminating as to the "usual and customary" procedures of any type of physician, based on the insurer's application of Medical Necessity Review to a particular type of service or treatment.
- Requires health plans, that do not predominately engage in Medical Necessity Review, but apply it to a particular type of service or treatment, to submit a report by December 15, each year, for a period of two years, to the DOI indicating:
  1. The type of services and treatments to which the plan applies Medical Necessity Reviews.
  2. The number of claims denied by health plans that the external independent review level of an appeal overturned.
- Requires DOI to review the information to ensure that the health plan, as a general business practice, does not use Medical Necessity Review in a discriminatory fashion.
- Makes a technical change.

SB1166. AHCCCS; Healthcare Group (Ch 332)

Expands Healthcare Group (HCG) eligibility, allows HCG to establish direct provider contracts and appropriates the HCG FY 2005 administrative budget. In 1985, the Legislature created HCG to provide affordable and accessible health care coverage to Arizona's small businesses with 50 or fewer employees and political subdivisions within the state. Currently, HCG provides a single, prepaid guaranteed HMO medical insurance option to Arizona small businesses.

Enacts A.R.S. § 20-2330:

- Permits an accountable health plan to contract with HCG to provide health care services.
- Stipulates that the HCG financial requirements imposed by Title 36, Chapter 29, Article 1, are separate from the financial requirements under the insurance code.
- Repeals A.R.S. § 36-2906.01, as amended by Laws 2001, Chapter 58, Section 19.
- Makes conforming changes to A.R.S. § 36-2906.01, as amended by Laws 2001, Chapter 344, Section 48 to enable accountable health plans to contract with HCG.

Amends A.R.S. § 36-2912:

- Authorizes AHCCCS to contract directly with any health care provider in areas where there is no willing contractor.
- Requires an employer group to wait at least 180-days from the date the group discontinues its health insurance under an accountable health plan before enrolling in HCG.
- An employer is exempt from the 180-day period if:
  1. The employer's accountable health plan discontinues offering the employer's particular health plan.
  2. The employer applied for HCG coverage before the effective date of the act. (Section 7 of SB1166)
- When calculating the employer's minimum percentage of enrollment requirements, excludes employees who have coverage through private insurance or another employer, and KidsCare parents who participate in AHCCCS' employer sponsored insurance program.
- Allows KidsCare parents who participate in the AHCCCS' employer sponsored insurance program to be eligible for HCG.

- Allows displaced persons who lost their jobs due to foreign trade and who qualify for a federal health coverage tax credit ("HCTC") pursuant to section 35 of the Internal Revenue Code of 1986 to be eligible for HCG, although, employment with a small business that elects HCG coverage does not apply to this eligibility group
- Beginning July 1, 2005, requires contractors, AHCCCS and accountable health plans to negotiate reimbursement rates with hospitals and prohibits the use of AHCCCS rates as a default reimbursement rate absent a contractor/provider contract.
- Requires the Director of AHCCCS to use monies from the HCG Fund to operate the HCG program.
- Allows HCG to pay insurance producers a one-time commission on the initial employer enrollment. Producers must certify that the employer group has not had coverage in the 180 days preceding their application to HCG.
- Requires AHCCCS to report to the Joint Legislative Budget Committee (JLBC) by June 15 and November 15 of each year on HCG participating businesses and marketing activities.
- Requires AHCCCS to notify JLBC (within 30 days of implementation) any changes in HCG benefits or cost sharing arrangements.
- Defines "accountable health plan" and "hospital."

Enacts A.R.S. § 36-2912.01 Healthcare Group Fund; non-lapsing:

- Establishes a separate exempt, non-lapsing, AHCCCS administered HCG fund, consisting of premiums paid by small employers and eligible employees, and gifts, grants, donations and legislative appropriations.
- Requires AHCCCS to use fund monies to pay administrative costs and the cost of providing hospitalization and medical care for small employers and eligible employees.
- Subjects administrative costs to operate the fund to legislative appropriation. Administrative costs exclude HCG insurance producer commissions or fees.
- Subject to legislative appropriation, AHCCCS may use fund monies derived from premiums to pay HCG administrative costs.

Enacts A.R.S. § 36-2912.02, Qualified commercial carriers; healthcare group contracts; definitions:

- Authorizes the director of AHCCCS to contract with an accountable health plan to provide services for healthcare group members.
- Requires accountable health plans that contract with AHCCCS to provide HCG services to comply with requirements of AHCCCS contracts and statutory provisions applicable to HCG contractors. Requires AHCCCS to monitor compliance and enforce the contract and statutory requirements.
- To the extent that services are provided pursuant to the HCG statute, insurance code requirements do not apply to an accountable health plan.
- Authorizes commercial insurers to contract with HCG without establishing a separate affiliate company.
- Exempts and appropriates a non-lapsing $3,207,400 from the HCG fund to AHCCCS in FY 2004-2005 for program administrative costs.
- Makes technical, clarifying and conforming changes.

SB1204. Occupational therapy (Ch. 130)

Codifies current practice by adding references to occupational therapy in laws regulating insurance claims, medical care cost recovery, prescriptions and massage therapy.

Amends A.R.S. §12-961 to expand the definition of medical care and treatment to include occupational therapy.

Amends A.R.S. § 20-115 to supplement the list of persons subject to the jurisdiction of the Department of Insurance to include a provider sponsored organization that operates under the Medicare-plus-choice program that provides coverage for occupational therapy.

Amends A.R.S. § 20-841.08:

- Prohibits a hospital service corporation or medical service corporation (that contractually provides both an in-network and out-of-network benefit for occupational therapy services) from denying a claim for covered occupational services obtained out-of-network solely on the basis that a physician did not refer the insured to the occupational therapist or prescribe specific occupational therapy services.
- Permits a service corporation to impose cost containment measures as a condition of coverage of occupational therapy services.

Amends A.R.S. § 20-1376.04:

- Prohibits an insurer that issues a disability insurance contract (that provides both an in-network and out-of-network benefit for occupational therapy services) from denying a claim for covered occupational services obtained out-of-network solely on the basis that a physician did not refer the insured to the occupational therapist or prescribe specific occupational therapy services.
- Permits a disability insurer to impose cost containment measures as a condition of coverage of occupational therapy services.

Amends A.R.S. § 20-1406.04:

- Prohibits an insurer that issues a group or blanket disability insurance contract (that provides both an in-network and out-of-network benefit for occupational therapy services) from denying a claim for covered occupational services obtained out-of-network solely on the basis that a physician did not refer the insured to the occupational therapist, or prescribe specific occupational therapy services.
- Permits a group disability insurer to impose cost containment measures as a condition of coverage of occupational therapy services.
- Allows a licensed occupational therapist or an athletic trainer to procure, store and administer non-scheduled legend, topical anti-inflammatories and anesthetics for uses within the scope of occupational therapy.

Amends A.R.S. § 32-4201:

- Specifies that the scope of practice for massage therapy does not include occupational therapy.
- Specifies that the practice of massage therapy does not include athletic training.
- Makes conforming changes

SB1238. Campaign finance; separate segregated fund

Allows an insurer licensed in Arizona to make up to two written solicitations for political contributions from a licensed insurance producer that has an exclusive contract to produce insurance business.

Amends A.R.S. §16-921:

- Permits an insurer licensed in Arizona or a separate segregated fund established by the insurer to make up to two written solicitations for political contributions during the calendar year from licensed insurance producers.
- Specifies that the insurer may solicit such contributions only from licensed insurance producers with whom the insurer has an exclusive contract.
- Stipulates that the section does not change the status of an insurance producer as an independent contractor.
- Provides definitions of "exclusive contract" and "insurance producer".
- Makes technical and conforming changes.

SB1241. Vehicle insurance; loss; vendor choice (Ch. 226)

Allows a person to choose any glass repair facility when having motor vehicle glass repaired and subjects a property and casualty insurer that fails to inform an insured about this right, to civil penalties. It also classifies an insurer's failure to recognize a valid assignment of a claim as an unfair claim settlement practice.

Amends A.R.S. § 20-456(B) to subject a property or casualty insurer that fails to recognize a valid assignment of claim, or to inform an insured about the right to choose any glass repair facility, to the civil penalties that the DOI Director may impose for a violation of prohibited acts, illegal or unfair methods of competition, or unfair or deceptive acts or practices.

Amends A.R.S. § 20-461 to add "the failure to recognize a valid assignment of a claim by property and casualty insurers" to the list of unfair claim settlement practices.

Adds A.R.S. § 20-469:

- Permits a person to choose any glass repair facility in the repair of a loss relating to motor vehicle glass, unless prescribed by contract.
- Requires an insurer that recommends or provides information about a glass repair facility to inform the person of the right to choose any glass repair facility at the time of the recommendation.
- Provides an insurer, with respect to the recognition of a claim, with the rights consistent with its policy provisions to receive notice of loss or claim and to all defenses regarding the loss or claim.
- Stipulates that the failure of an insurer to inform an insured about the right to choose any repair facility creates an administrative remedy only and does not create a private cause of action.
- Makes technical and conforming changes.

SB1256. Workers' compensation; insurance carriers (Ch. 307)

Amends the deposit requirements for insurers transacting workers' compensation insurance in Arizona. Also changes the Special Fund and the State Compensation Fund (SCF) reimbursement procedures, in the event an insurance carrier or employer fails to pay workers' compensation claims.

Amends A.R.S. § 23-961:

- Authorizes DOI to require financial information to compute the deposit formula as of a time other than the preceding December 31st.
- Continues to mandate that an insurance carrier file the required information for the deposit formula annually, on or before April 15, but now gives DOI authority to request the information at any time.
- Requires a workers' compensation insurer to deposit any additional amount the DOI requires.
- Removes the option for an insurance carrier to furnish a bond to fulfill the deposit requirement to transact workers' compensation insurance in Arizona and allows the carrier to deposit cash or securities with the State Treasurer to meet the requirement.
- Requires the DOI Director to hold cash carriers' or securities, including a carrier acting as a reinsurer, for fulfillment of the workers' compensation obligations.
- Stipulates that the Industrial Commission has a lien against the carriers' cash or securities, to the extent the Special Fund is liable to pay the obligations secured by the deposit.

Amends A.R.S. § 23-966:

- Requires the SCF to process workers' compensation claims and pay the amount due on behalf of and under the direction of the Special Fund when an insurance carrier, self-insured employer or other employer authorized to process workers' compensation claims directly fails to pay a claim.
- Requires the Special Fund to reimburse the SCF (at least quarterly) for the compensation, benefits, or amounts paid, together with reasonable administrative costs, necessary expenses and reasonable attorney fees.
- Authorizes the Special Fund to expend monies for necessary expenses to assist in the determination of the liability of a workers' compensation claim.
- States the Special Fund has a claim against the insurance carrier or employer for all costs associated with the failure of the insurance carrier or employer to pay a workers' compensation claim.
- Specifies any insurance carrier or employer may make a Special Fund claim against the cash, securities, bond or other assets of the Insurance carrier or employer.
- Authorizes the Industrial Commission to increase the assessment for the Special Fund in order to reimburse the Special Fund for any net loss incurred.
- Requires the Industrial Commission, Special Fund and the SCF to develop and implement a transition process for implementation of the changes in the reimbursement procedures and allows them to enter into any appropriate interagency agreements or other agreements.
- The changes to the reimbursement procedures apply to the assignment of any insurance carrier or employer workers' compensation claim that occurs before or after the procedure's effective date.
- Grants the Special Fund the same rights as the SCF with regard to claims previously assigned to the SCF and assets against which the SCF has made a reimbursement claim.

- Requires the SCF to continue to pursue a claim for reimbursement on behalf of the Special Fund should the Special Fund be prohibited from exercising its right to make a claim on the assets of the insurance carrier or employer.
- Requires DOI to continue to apply and enforce its interpretations and practices regarding approved reinsurance as they existed on December 31, 2003 until the Legislature enacts further legislation regarding approved reinsurance.
- Makes technical and conforming changes.

SB1366. Department of Administration; self-insurance; benefits (Ch. 335)

Requires the Arizona Department of Administration (ADOA) to provide all health coverage benefits mandated by Arizona Revised Statutes, Title 20 in the Self-Insurance program.

Amends A.R.S. § 38-651:

- Requires ADOA to provide all health coverage benefits mandated by Arizona Revised Statutes, Title 20 in the Self-Insurance program.
- Requires the Self-Insurance program to include protection of state officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues.
- Allows, rather than requires, ADOA to designate the Arizona Health Care Cost Containment System (AHCCCS) as a qualifying health plan for state employees and their dependents.
- Requires ADOA to allow school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities, or organized public entities, to participate in any health plan offered by ADOA that is subject to Title 20.
- Permits school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities or organized public entities to apply to ADOA to participate in the Self-Insurance program.
- Requires school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities or organized public entities participating in the self-insurance program to reimburse ADOA for all premiums and administrative or other insurance costs.
- Requires ADOA to actuarially prescribe the annual premium to ensure that each participating entity bears the actual cost of its participation.
- Allows any current participating entity to continue to participate using any ADOA plan.

SB1381. Insurance; employee, union groups (Ch. 159)

SB 1381 reduces the number of employees required for group life insurance eligibility from ten to two and reduces the labor union membership eligibility from twenty-five to two.

Amends A.R.S. § 20-1252 to require a policy of group life insurance issued to employee groups to cover at least two employees.

Amends A.R.S. § 20-1254 to require a policy of group life insurance issued to a labor union to cover at least two union members on the date of issue.

Amends A.R.S. § 20-1276 to make conforming changes to the definition of “employee life insurance”.

HB2181. School districts; agencies; insurance pools (Ch. 230)

This bill permits public agencies and school districts to enter into contracts or agreements for additional types of insurance and retention of risks, allows community college district governing boards to participate in public agency pools and self insurance programs and provides for the formation of cooperative procurement entities.

Amends A.R.S. §11-952 governing intergovernmental agreements and contracts to allow public procurement units to contract for services, jointly exercise powers or enter into agreements with public agencies or other public procurement units.

Amends A.R.S. §11-952.01 to allow public agencies to enter into contracts or agreements for the joint purchasing of prepaid legal insurance or reinsurance, to pool retention of their risks for fidelity losses and to provide for the payment of fidelity losses or prepaid legal insurance for any member of the pool.

Amends A.R.S. §15-382 governing authorization to self-insure to:

- Allow school district governing boards to enter into intergovernmental agreements or contracts with insurance pools.
- Allow programs offered by public agency pools to include the joint purchasing of prepaid legal insurance.
- Specifies that school district governing boards may contract with a trustee or board of trustees that provide a common self-insurance program or programs with pooled funds and risks to community college districts.
- Requires school districts that self-insure for liability losses to obtain reinsurance in the same manner as excess liability coverage.

Amends A.R.S. §15-387 governing procurement of insurance to add fidelity losses and legal expenses to the list of losses or expenses for which a school district governing board may procure insurance or provide a self-insurance program. Also specifies that claims can be paid on behalf of leased employees as well as for other district employees.

Amends A.R.S. §15-1444 governing general powers of district governing boards:

- Allows a community college district board to contract with a trustee or board of trustees that provides a self-insurance program with pooled funds and risks to community college districts.
- Allows community college district governing boards to enter into intergovernmental agreements or contracts for participation in programs offered by public agency pools.
- Specifies that the board is not required to engage in competitive procurement to participate in these programs.

Amends A.R.S. § 41-621.01 governing the pooling of property, liability and workers' compensation coverage to remove the requirement that the majority of board members for pools created by contractors or subcontractors be elected officials or employees of the state.

Expands the definition of "local public procurement unit" in A.R.S. § 41-2631(2) to include "any nonprofit corporation created solely for the purpose of administering a cooperative purchase under this article."

As a result of this definitional change, two or more political subdivisions may now enter into contracts or agreements to conduct cooperative procurement of materials and services pursuant to statute or by the joint formation of a non-profit corporation.

Requires a nonprofit corporation operating as a public procurement unit, upon the request of the Auditor General, to provide documentation of any cooperative purchasing transaction administered by the public procurement unit.

Mandates that a nonprofit corporation administering a public procurement unit comply with all procurement laws applicable to the public procurement unit. The statute also states that the latter provision does not absolve each public procurement unit of its responsibility to ensure compliance with the procurement laws even though the cooperative purchase is administered by a nonprofit corporation.

HB2241. Department of financial institutions (Ch. 188)
(Delayed effective date of January 1, 2006)
HB2241 changes the name of the State Banking Department to the Department of Financial Institutions.

Amends A.R.S. § 6-110 to change the name of the Banking Department to the Department of Financial Institutions.

Amends A.R.S. § 6-111 to include among the minimum qualifications for the Superintendent of the Department of Financial Institutions experience in the financial institution business.

Amends A.R.S. § 46-138.01 to codify current practice by removing the requirement that the Public Assistance and Administration Revolving Fund administered by the State Department of Public Welfare must be deposited into a bank that is on an approved list by the Banking Department.

Makes technical, clarifying and conforming changes.

HB2433. Health care district; self-insurance (Ch. 141)
HB2433 allows special health care districts and political subdivisions (located in a county with a population of more than one million that are governed by the county board of supervisors) the authority to establish a self-insurance program.

A.R.S. § 11-981 authorizes any city, town or county in the state of Arizona to procure insurance from any insurer authorized by the Arizona Department of Insurance, or establish a self-insurance program. If a self-insurance program is implemented by a city, town or county, the governing body of such city, town or county must place all funds into a trust fund for direct payment of benefits, losses or claims pursuant to the self-insurance guidelines. In addition to other requirements, the trust fund must be administered by at least five bonded joint trustees, contain a stop-loss provision, and be audited by an external auditor annually. HB2433 would allow special health care districts and political subdivisions located in a county with a population of more than one million that are governed by the county board of supervisors the authority to establish a self-insurance program

HB2433 amends A.R.S. §11-981 to add the following entities to the list of public entities that can procure insurance or establish a self-insurance program:

- Special health care districts.
- Political subdivisions located in a county with a population of more than one million and which is governed by members of a county board of supervisors.

It also subjects special health care districts and political subdivisions that establish self-insurance programs to the other requirements imposed by A.R.S. §11-981 and makes technical and conforming changes.

HB2458. Taxis, limousines, sedans; regulation (Ch. 323)
(Delayed effective of December 31, 2004; changes the delayed effective date of Laws 2003, Chapter 168 to December 31, 2004.)

HB2458 makes changes to the self-insurance statues governing motor carriers by allowing for captive insurance, self-insurance or partial self-insurance. In the case of self-insurance or partial self-insurance, the motor carrier must demonstrate it is able to meet requirements establishing that the person or entity is financially able to pay the entire amount of self-insurance, and files a bond for the amount of self-insurance with the Director of the Arizona Department of Transportation (ADOT).

Amends definitions in A.R.S. §§ 28-101 and 41-2051.

Amends A.R.S. § 28-3564 to require the Director of ADOT and the Director of the Department of Weights and Measures to develop procedures to exchange and record information electronically between the departments.

Amends A.R.S. § 28-4007:

- Decreases the number of vehicles (from 25 to 10) a person or entity must have registered to qualify as a self-insurer.
- Requires the Director of ADOT to determine that a person or entity is financially able and will continue to be able to pay judgments obtained against the person or entity before issuing a certificate of self-insurance.
- Authorizes the Director of ADOT to cancel a certificate of self-insurance or a certificate of partial self-insurance based on “reasonable grounds” after not less than five days’ notice and a hearing.
- Establishes additional “reasonable grounds” for cancellation of a certificate of self-insurance.
- Enacts subsection (E) to allow a person to qualify as a self-insurer if the person or entity is insured by a captive insurer that is domiciled and authorized by the Department of Insurance to transact business in Arizona and that provides coverage in an amount at least the amount required in statute for taxis and limousines.
- Enacts subsection (F) to require a person or entity applying for self-insurance to:
  1. Submit evidence in a form prescribed by the Director of ADOT that the person or entity is financially able, and will continue to be able, to pay, the entire amount of self-insurance allowed by ADOT for judgments obtained against the person or entity for liability arising out of the ownership, maintenance or use of a motor vehicle.

2. If applicable, submit evidence that the person or entity has a valid insurance policy that meets the requirements prescribed in A.R.S. § 28-4033, issued by an insurer that holds a certificate of authority or a permitted surplus lines insurer in Arizona.

- Enacts subsection (G) to authorize the Director of ADOT to adopt rules regarding the financial responsibility requirements.
- Authorizes the Director of ADOT, in consultation with the Director of the Department of Insurance (DOI) to establish procedures that allow a person or entity to apply for and file a certificate of either partial self-insurance or self-insurance.
- Enacts subsection (H) to require the Director of ADOT, in consultation with the Director of DOI, to establish procedures to exchange information regarding changes in self-insurance status.

Enacts A.R.S. § 28-4011 relating to bonds for self-insurers:

- Requires a self-insurer to file a bond with the Director of ADOT, issued by a surety company authorized by the Corporation Commission to transact business in Arizona, with the self-insurer as the principal obligor and Arizona as the obligee on the bond.
- Requires the bond to be conditioned on the self-insurer's compliance with laws governing motor carriers.
- Requires the Director of ADOT to set the total amount of the bond and authorizes ADOT to increase or reduce the bond amount at any time, subject to statutory limitations.
- Requires the bond for a self-insurer to be at least $250,000.
- Allows a self-insurer to submit requests to the Director to reduce a bond amount.
- Authorizes ADOT to grant such request, provided the self-insurer has (a) continuously complied with Article 1, Chapter 9 of Title 28; and, (b) has not incurred any claims for motor vehicle accidents for at least the previous three consecutive years.
- Authorizes the ADOT to retain or increase a bond if ADOT determines that a reduction of the bond amount would jeopardize public safety.
- Also allows a person aggrieved by ADOT's decision to appeal and request a hearing.
- Authorizes ADOT to order the self-insurer to file a new bond with satisfactory sureties in the same amount as the original bond under certain circumstances.
- Requires ADOT to cancel the certificate of self-insurance immediately, if the self-insurer fails to file a new bond as required.
- Requires ADOT to cancel and surrender the original bond if the self-insurer furnishes a new bond.
- Requires the self-insurer to file an additional bond in an amount approved by ADOT immediately if the Director of ADOT decides that the amount of the existing bond is insufficient to ensure the safety of the public.
- Mandates that the Director cancel the certificate of self-insurance of the person immediately if the self-insurer fails to file an additional bond as required.
- Provides that upon filing a written request to the Director, the state shall release and discharge a surety on a self-insurer bond from all liability to the state accruing on the bond as of the last day of the month that includes the sixtieth day after the filing of such written request.
- Provides that a request for release from liability does not relieve, release or discharge the surety from liability already accrued, or accrued before the last day of the month that included the end of the sixty-day period.

- Requires ADOT, on receipt of the request, to (a) notify the self-insurer who furnished the original bond; (b) cancel the certificate of self-insurance immediately, unless the self-insurer files a new bond within sixty days; and, (c) cancel and surrender the original bond.

Amends A.R.S. § 28-4033 relating to Financial Responsibility Requirements:

- Requires that a vehicle with a seating capacity of less than sixteen passengers (including the driver), but more than eight passengers (including the driver) have minimum liability coverage in the amount of $750,000 and uninsured motorist coverage of at least $300,000.
- Amends the minimum uninsured motorist coverage amount for vehicles with a seating capacity of not more than eight passengers (including the driver) from $750,000 to $300,000.
- Specifies that financial responsibility registration suspensions for taxis, livery vehicles, and limousines pertain only to those motor vehicles registered to the owner of the vehicle specified in the suspension.

Amends A.R.S. § 41-2096 relating to signage in taxis, livery vehicles and limousines.

Allows ADOT to hire one full time employee for the increased workload related to the insurance provisions of this legislation.

HB2681. Hospital liens; enforcement (Ch. 154)

HB2681 prohibits health care providers and ambulance operators from enforcing a lien against an injured person's underinsured or uninsured motorist coverage.

Amends A.R.S.§33-931, governing health care provider liens on damages recovered by persons receiving services:

- Provides that liens by health care providers and ambulance operators shall not extend to an injured person’s underinsured and uninsured motorist coverage
- Exempts hospitals and ambulance services from the lien perfecting requirement to list the names and addresses of, and mail a copy to, all persons or entities that may be liable to the injured person
- Provides that a hospital or ambulance service lien is effective against any settlement or judgment if the lien is recorded 30 days before the settlement date or the judgment is paid.

Amends A.R.S §33-934 governing actions to enforce liens:

- Permits a lienholder to enforce the lien by action against any insurer that is responsible for paying damages to the injured person
- Permits an award of attorney fees to the prevailing party in an action to enforce the lien.
- Provides that the lienholder cannot recover more than the amount of the lien
- Provides that a defendant in a lien action may dispute the amount of the lien on the grounds that it is erroneous or exceeds customary charges or that the care or treatment was not medically necessary or causally related to the event giving rise to the claim.

SB1113. Expert testimony; affidavits; health professionals (Ch. 4)

Adds lawsuits against health care professionals to the class of lawsuits that require expert certification before the plaintiff can proceed with the case.

Enacts A.R.S. §12-2602.01:

- In a civil action against a health care professional, a claimant, or the party designating a nonparty at fault, or their attorney must file and serve a written statement certifying whether or not expert opinion testimony is necessary to prove the health care professional's standard of care. or liability for the claim.
- Certification is required in cases against a licensed health care professional in which the professional is designated a nonparty at fault.
- If a claimant certifies that expert testimony is necessary, the claimant must serve a preliminary expert opinion affidavit with the initial disclosures required by Rule 26.1, Arizona Rules of Civil Procedure.
- If a party designating a nonparty at fault certifies that expert testimony is necessary, that party must serve a preliminary expert opinion affidavit within 60 days after filing the designation.
- At a minimum, the preliminary expert opinion affidavit must contain the following information:
  1. The expert's qualifications to render an opinion on the health care professional's liability or standard of care.
  2. The factual basis for each claim against the health care professional.
  3. The acts, errors or omissions of the health care professional that the expert considers to be a violation of the applicable standard of care.
  4. The manner in which the acts, errors or omissions of the health care professional caused or contributed to the damages or other relief sought by the claimant.
- Authorizes the court, upon good cause shown or by stipulation of the parties, to extend the time for compliance with this section. If the court grants an extension, it may also adjust the timing and sequence of disclosures against the health care professional.
- Permits good faith challenges to certification that expert testimony is necessary to prove the claim and allows the claimant or health care professional may move for a court order requiring the claimant or the party designating the nonparty at fault to serve a preliminary expert opinion affidavit. The motion for a preliminary expert opinion affidavit must identify:
  1. The claim for which expert testimony is needed.
  2. The prima facie elements of the claim.
  3. The legal or factual basis for the contention that expert testimony is required to establish the standard of care or liability for the claim.
- Requires the court to stay all other proceedings and time periods concerning the claim, pending the court's consideration and ruling on the motion.
- Upon ruling such compliance is necessary, the court to set a date and terms for compliance.
- Requires the court, either on its own motion or upon motion by the health care professional to dismiss the claim against the health care professional if the party filing the claim fails to file and serve a preliminary expert opinion affidavit (1) after certifying that one is necessary, or, (2) the court has ordered the party to file and serve an affidavit.
- Requires the court to allow any party a reasonable time to cure an affidavit in response to an allegation that the affidavit is insufficient.
- Permits a claimant, or party designating a nonparty at fault, to supplement a claim or affidavit with additional claims, evidence or expert opinions, timely disclosed under the Arizona Rules of Civil Procedure, or pursuant to court order.
- A preliminary expert opinion affidavit may be used for impeachment only upon the court's finding that:
  1. The facts upon which the expert based the affidavit have not substantially changed since the date of the affidavit.
  2. The expert had knowledge of the facts at the time he prepared the affidavit.
- Provides definitions of "claim" and "expert."

- Provides that the intent of the Legislature is to curtail the filing of frivolous lawsuits.

SB1311. Purchaser of dwelling actions (Ch. 216)

Prohibits a purchaser from filing a multiunit dwelling action without first complying with the alternative dispute resolution procedures and requires a seller's insurance company to treat a notice of alleged damages from a purchaser as a claim under the insurance policy.

Amends A.R.S. §12-362:

- Requires a purchaser to first comply with the alternative dispute resolution procedures before filing a multiunit dwelling, action unless the claim alleges defects posing an immediate threat to the life or safety of persons occupying or visiting the dwelling.
- Requires a seller's insurance company to treat a purchaser's alleged defects notice received by the seller as a notice of claim subject to the terms and conditions of the insurance policy. This provision applies only if the policy covers the seller's liability arising out of the design, construction or sale of the property that is the subject of the notice.
- To effectuate the purpose of the statute, requires the seller's insurance company to work cooperatively and in good faith with the seller within the time frames of the alternative dispute resolution procedures.
- The statute does not otherwise affect the coverage under the insurance policy and does not create a cause of action against an insurer whose actions were reasonable under the circumstances, even if an insurer fails to comply with the alternative dispute resolution timeframes.

Amends A.R.S. § 12-1363:

- Requires a purchaser to give written notice specifying the basis of the dwelling action in reasonable detail (certified mail, return receipt requested) to the seller 90 days at least before filing a dwelling action.
- Requires the purchaser of a dwelling, upon rejection of a seller's written offer to repair alleged damage, to include in the written response to the seller the specific factual basis for the rejection, provided the seller had disclosed the specific factual basis for the offer.
- Eliminates the specification of information that is admissible in any dwelling action.
- Makes technical and clarifying changes.

Any person may view this bulletin on the Department's web site at www.id.state.az.us. For questions regarding this bulletin, please contact Jennifer Boucek, Executive Assistant for Policy Affairs at 602/912-8456 or jboucek@id.state.az.us.